U.S. Department of Labor

Office of Administrative Law Judges
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Issue Date: 30 December 2003 Case No.: 2003-BLA-5157

In the Matter of:

ANGELO PRUNESTI,
Claimant

v.

ANKER WEST VIRGINIA
MINING COMPANY INC.,
Employer

and

WEST VIRGINIA COAL WORKERS'
PNEUMOCONIOSIS FUND,
Carrier

and

DIRECTOR, OFFICE OF WORKERS'
COMPENSATION PROGRAMS,
Party-in-Interest

BEFORE: ROBERT J. LESNICK
Administrative Law Judge

APPEARANCES:

Frederick K. Muth, Esquire,
For the Claimant

Robert Weinberger, Esquire,
For the Employer

DECISION AND ORDER AWARDING BENEFITS

This proceeding arises from a claim for benefits filed by Angelo Prunesti, under the Black Lung Benefits Act, 30 U.S.C. § 901, *et. seq*. ("the Act"). The Act's implementing regulations are included in Title 20 of the Code of Federal Regulations ("C.F.R."), Parts 718 and 725 ("the Regulations"). The current claim was filed on January 23, 2001. (DX 2).

Black lung benefits are awarded to coal miners who are totally disabled by pneumoconiosis caused by coal mine dust exposure, and to the surviving dependents of coal miners whose death was caused by pneumoconiosis. 20 C.F.R. § 718.1. The Act and Regulations define pneumoconiosis (commonly known as "black lung disease" or "coal workers' pneumoconiosis" ("CWP")) as a chronic lung disease and its sequelae, including respiratory and pulmonary impairments, arising out of coal mine employment. 20 C.F.R. § 718.201.

The findings of fact and conclusions of law set forth in this decision are based upon my analysis of all of the admissible evidence in the record. Each exhibit and argument of the parties, although perhaps not specifically mentioned, has been carefully reviewed and thoughtfully considered. While the contents of certain medical evidence in the record may appear inconsistent with the conclusions reached in this decision, it should be considered that the appraisal of the relative merits of each item of medical evidence has been conducted in conformance with the quality standards of the Regulations.

Section numbers hereinafter cited exclusively pertain to Title 20, Code of Federal Regulations. References to DX, CX, EX, and ALJX refer to exhibits of the Director, the Claimant, the Employer, and this Court, respectively. References to the hearing transcript are cited as "TR", followed by the page number.

PROCEDURAL HISTORY

The Claimant filed his first claim for benefits on February 2, 1993. A determination was made that the Claimant had established 34.17 years of underground coal mine employment. On July 6, 1993, the Claims Examiner denied the claim for benefits, concluding that the Claimant had failed to establish that he had pneumoconiosis, the disease was caused by coal mine dust exposure, or that he was totally disabled by the disease. (DX 1). No further action was taken on that claim.

The Claimant filed the present claim for benefits on January 23, 2001. (DX 2). On October 24, 2001, the Claims Examiner issued a Schedule for Submission of Additional Evidence, in which initial determinations were made that the Claimant would be entitled to benefits, based on the information at that time, and that the named coal mine operator was the proper Responsible Operator liable for payment of benefits. (DX 18).

On June 27, 2002, the District Director issued a Proposed Decision and Order denying benefits. (DX 24). The District Director found that the Claimant had been employed in the coal mines for 34 years, that he filed a timely claim for benefits, and that the named employer is properly identified as the Responsible Operator, liable for payment of benefits. The District Director found, however, that the evidence failed to establish the existence of pneumoconiosis, that the disease was caused, at least in part, by coal mine dust exposure, or that he was totally disabled by the disease.

The Claimant, on July 18, 2002, requested additional time to submit evidence. (DX 25). The District Director denied that request on August 5, 2002. (DX 26). By letter dated August 8,

2002, The Claimant subsequently requested a hearing. (DX 27). The claim was transmitted to the Office of Administrative Law Judges on November 1, 2002. (DX 30).

The case was assigned to the undersigned, and a Notice of Hearing was issued on April 10, 2003. A hearing was held on August 5, 2003, in Beckley, West Virginia. During the hearing, Director's Exhibits (DX) 1 through 32 were admitted into the record. (TR 5). The Claimant entered 2 exhibits into the record, which are marked as CX 1 and 2. The Employer submitted two exhibits, EX 1 and 2, into evidence.[1] The Employer's Pre-Hearing Report is admitted into the record, identified as ALJX 1; the Claimant's Pre-Hearing Report is in evidence as ALJX 2. The Claimant submitted his closing brief on September 9, 2003, and a brief on behalf of the Employer was submitted on September 22, 2003.

ISSUES

The following contested issues remain for determination:

I. Whether the Claimant has established a material change in conditions?
II. Whether the Claimant has pneumoconiosis as defined by the Act and the Regulations?
III. Whether the pneumoconiosis arose, at least in part, out of coal mine employment?
IV. Whether the Claimant is totally disabled?
V. Whether the Claimant's total disability is due to pneumoconiosis?

(DX 30; TR 5-6).

FINDINGS OF FACT

Background

Angelo Prunesti ("the Claimant") was born on February 2, 1937. (DX 2; TR 12). His formal education ended with the 11th grade. (DX 2; TR 12). He married the former Alice Faye Jones on October 25, 1958. (DX 2, 10; TR 12). The Claimant began working in the coal mines in April 1956, and his jobs included working on the conveyor, as a shuttle car operator, an underground foreman, a scoop operator, shift supervisor, and mine superintendent. (DX 3, 5). Mr. Prunesti's last coal mine job was that of a general inside laborer and fire boss pumper, which he held until he left the mines. (DX 3; TR 14). Mr. Hamilton stopped working in the mines on March 19, 1999, because he no longer believed he could do a satisfactory job. (DX 2; TR 15).

[1] These exhibits were admitted into evidence as duplicative exhibits. Employer's Exhibit 1 (EX 1), the X-ray reading of Dr. Wiot, is also in the record as DX 22; the medical report of Dr. Zaldivar, EX 2, is also identified in the record as DX 23.

Pneumoconiosis and Related Issues

I. Medical Evidence

A. Chest X-rays

Exhibit No./ Physician	X-ray Date	Reading Date	Qualifications[2]	Impression
DX 1 Daniel	2/24/93	2/25/93	BCR	2/1; q/t; all three left zones and right upper and middle zones. Category A. Film quality "1".
DX 1 Sargent	2/24/93	3/19/93	B, BCR	No parenchymal or pleural abnormalities consistent with pneumoconiosis. Ill-defined nodules; unknown etiology. Film quality "2".
DX 11 Patel	4/19/01	5/3/01	B, BCR	1/1; s/s; 6 zones. Lungs mildly hyperinflated, bronchovascular markings generally thickened; poorly detailed right upper zone mass, 2cm in diameter (likely Category A large opacity) classifiable as complicated pneumoconiosis; coalescence of small opacities in left upper lung zone. Film quality "2" for bilateral scapular overlap, and slight lateral underexposure.
DX 12 Binns	4/19/01	6/25/01	B, BCR	? mass right upper lung. Quality "2" film – left CPA cat.
DX 22; EX 1 Wiot	4/19/01	11/13/01	B, BCR	0/1; r/r; 3 left zones. No evidence of CWP; changes in right upper lobe consistent with granulomatous disease with stranding extending from the right hilum indicating past inflammatory process. Film quality "2".
DX 23; EX 2 Zaldivar	1/9/02	2/25/02	B	No parenchymal or pleural abnormalities consistent with pneumoconiosis. Film quality "1".
CX 1 Cappiello	7/24/02		B, BCR	Complicated pneumoconiosis with large opacity, Category A; small opacities 2/2; p/q; coalescent opacities left upper lobe, ax; right chest wall pleural thickening, grade B, extent 3. Film quality "2" – left scapular overlay and slight overexposure.

B. Pulmonary Function Studies

Exhibit No./ Physician	Date	Age/ Height	FEV_1	MVV	FVC	Tracings	Qualifying
DX 1 Daniel	2/24/93	56 68"	2.90	114	4.14	Yes	No
DX 11	4/19/01	64	2.68	99	4.33	Yes	No

[2] B = NIOSH B-reader; BCR = Board-certified Radiologist

Rasmussen		69”					
DX 23; EX 2 Zaldivar	1/9/02	64 70”	2.58 2.68*	57 67*	4.31 4.38*	Yes	No No*

* Results post-bronchodilator

C. Arterial Blood Gas Studies

Exhibit No.	**Date**	**pCO_2**	**pO_2**	**Qualifying**
DX 1	2/24/93	31.9 35.7* 35.1* 34.5*	88 82* 81* 79*	No No* No* No*
DX 11	4/19/01	35 37*	76 69*	No No*
DX 23; EX 2	1/9/02	30 36*	91 71*	No No*

* Results post-exercise

D. CT Scan

A CT scan of the Claimant’s chest was taken on June 4, 1999, and interpreted by Dr. Enrico Cappiello on November 6, 2002. (CX 1). Dr. Cappiello noted that the scan was technically limited due to lack of IV contrast. Dr. Cappiello observed a large spiculated mass in the upper right lobe, measuring three centimeters, which in all probability was complicated pneumoconiosis. Dr. Cappiello stated his reading of the CT scan correlated with the July 24, 2002 X-ray. He further noted that the mass was not likely a neoplasm because there was no significant growth in the right upper lobe mass. He likewise noted many small opacities in both lungs favoring the upper lobes, which represented small opacities of pneumoconiosis. Dr. Cappiello thus concluded that the CT scan revealed complicated pneumoconiosis.

E. Medical Opinions

Dr. D.L. Rasmussen examined the Claimant on April 19, 2001; he completed the Department of Labor form and submitted a full report. (DX 11). He noted the Claimant’s employment history, family history, medical history, and a smoking history of less than one-half of a pack of cigarettes per day from 1954 to 1985. Dr. Rasmussen found the Claimant’s chief complaints to include: Minimal morning sputum production; wheezing when lying down; dyspnea for over 10 years, but not after 1 flight of stairs; minimal cough in the morning; and chest pain, described as an upper substernal tightness or soreness, but not effort-related.

Dr. Rasmussen diagnosed the Claimant with complicated pneumoconiosis, based on his 40 years of coal mine employment and the X-ray evidence. He further diagnosed chronic bronchitis, based on the Claimant’s chronic productive cough. Dr. Rasmussen identified coal

mine dust exposure as the etiology for the complicated pneumoconiosis and a combination of coal mine dust exposure and cigarette smoking as the etiology for the chronic bronchitis. Dr. Rasmussen stated that Mr. Prunesti has a minimal loss of lung function and retains the pulmonary capacity to perform his last regular coal mine job. The two identified risk factors for his impairment are cigarette smoking and coal mine dust exposure, the latter of which is a major contributing factor.

Dr. George Zaldivar examined the Claimant on January 9, 2002, and issued a report dated February 25, 2002. (DX 23; EX 2). The physician noted the Claimant's medical, employment, personal and family histories. His findings included an abnormal chest X-ray with a mass lesion in the right upper lobe, a mild irreversible airway obstruction, normal lung volumes, a mild diffusion impairment, a mild limitation to exercise with a mild rise in pCO_2, and low carboxyhemoglobin of a current non-smoker.

Dr. Zaldivar concluded that there was no evidence to justify a diagnosis of coal workers' pneumoconiosis. He also found a mild pulmonary impairment, which is not the result of his coal mine work, but rather, due to a mild bronchospasm during exercise. Dr. Zaldivar opined that from a pulmonary standpoint, Mr. Prunesti could perform his usual coal mine work, or work requiring similar exertion; thus, he stated that the Claimant was not disabled, except for back problems due to an orthopedic condition. Finally, Dr. Zaldivar recommended that the Claimant contact his physician about the X-ray findings. The physician commented that the chest X-ray revealed a mass lesion in the right upper lobe. While he could not see a background of simple pneumoconiosis, and he believed it was a tumor, he stated that it was possible that the lesion was due to pneumoconiosis.

Dr. Enrico Cappiello was deposed on July 30, 2003. (CX 2). He stated that, based on the X-ray and CT scan that he reviewed, he diagnosed category A complicated pneumoconiosis with background simple pneumoconiosis. (*Id.* at 4-5). Dr. Cappiello testified that the nodule could have been indicative of a granulomatous process, but it was unlikely because of the appearance of the small opacities. (*Id.* at 5). According to Dr. Cappiello, the shape of the nodule, as seen on the CT scan, is "more suggestive of a large opacity pneumoconiosis, because of its shape, and also the fact that you see many of the smaller opacities scattered throughout both lungs." (*Id.* at 6). He added that the smaller opacities could be better seen on the X-ray. (*Id.* at 6). In addition, Dr. Cappiello did not see calcified lymph nodes in mediastinum or the right hilum, and the shape and appearance of the opacities were more characteristic of pneumoconiosis. (*Id.* at 8-9). Thus, Dr. Cappiello opined that the diagnosis was likely not a granulomatous process. (*Id.*)

Dr. Cappiello likewise noted that he also considered that the nodule was cancer; however, he opined that if the nodule on the 1999 CT scan was a tumor, it is unlikely that the patient would be alive by 2002. (*Id.* at 8). Moreover, cancer grows; the nodule Dr. Cappiello observed had not grown in size. (*Id.*)

The physician testified that he was better able to make an assessment having reviewed both the CT scan and the X-ray. He stated that the opacity is wider in transverse dimension than in the AP dimension, and was much more apparent on the CT scan than on an X-ray without a lateral view. (*Id.* at 8-9). On cross-examination, Dr. Cappiello admitted that the CT scan was

limited because it was a conventional scan, most likely because of a fear that the large nodule was cancer. (*Id.* at 13). For pneumoconiosis, it would have been better to use a high resolution study with thinner slices. (*Id.*) Despite the scan's limitations, however, Dr. Cappiello said that the study is sufficient to conclude that there is a large opacity, and smaller opacities, most likely pneumoconiosis, accompanying the large opacity. (*Id.* at 15-16).

II. Lay Testimony

Mr. Prunesti testified at the August 5, 2003 hearing. He stated that his last coal mine job for the Employer was that of a fire boss pumper. (TR 14). He said that his job entailed examining all intake and return air courses, ensuring air flowed in the correct direction, and checking air velocity, ensuring the proper amount of air was entering into the sections and returning. (*Id.*) The Claimant noted that he had to carry a bag with him that included a screwdriver, pliers, hammer, instrument for reading air velocity, methane detector, splicing material for water pumps, self-rescuer, mine light, and a battery. (TR 14-15). He estimated that these materials weighed 15 pounds. (TR 15). The Claimant also said that he spent a substantial amount of time on his feet in the mines, walking approximately 2 miles per day, and doing additional crawling. (*Id.*)

The Claimant said that he left the mines voluntarily in March 1999, because he no longer felt he could do his job satisfactorily, based on his assignments and the materials he had to carry. (TR 15). The Claimant noted that he had experienced shortness of breath for 15-20 years, however, he is not currently being treated for his breathing problems. (TR 16). He opined that his breathing problems would prevent him from returning to his last job.

On cross-examination, Mr. Prunesti estimated that he smoked one-half of a pack of cigarettes per day, from approximately 1957 through 1985, periodically quitting, for as much as six or eight months at a time. (TR 17). He described his day, noting that he does very few chores around the house. (TR 18).

CONCLUSIONS OF LAW

Length of Coal Mine Employment

The Claimant claimed a total of 42 years of coal mine employment. (DX 2; TR 14). The calculation in the first claim resulted in a finding of 34.17 years. (DX 1). The District Director in the instant claim found 34 years of coal mine employment. (DX 24). Likewise, the Employer stipulated to 34 years of coal mine employment. (TR 5-6).

I note that the Social Security earnings records included in the file are incomplete. (DX 8). The record also includes employment records submitted by previous employers. (DX 5, 6 & 7). After reviewing all of the evidence, including the Claimant's statements, the Social Security records, previous employment records, and the District Director's findings, I find that the Claimant has established 39.5 years of coal mine employment.

Responsible Operator

The District Director has determined that the named Employer is the properly designated responsible operator. (DX 17). The Employer has not objected to this designation. (TR 5-6). After reviewing the record, I find that the Employer is properly designated as the responsible operator in this matter.

Dependents

The Claimant married his wife, Alice Faye Prunesti, on October 25, 1958. She is properly identified as the sole dependent for augmentation of benefits.

Date/Timeliness of Filing

The Claimant stopped working in the mines on March 19, 1999. His first claim for benefits was filed on February 2, 1993, and denied on July 6, 1993. No further action was taken on that claim. This claim for benefits, the Claimant's second, was filed on January 23, 2001. The District Director has previously found that this claim was timely filed. The Employer has not contested this issue. Accordingly, I find that the Claimant's instant claim for benefits has been timely filed.

Entitlement to Benefits

I. Determination of Pneumoconiosis

In order to recover benefits under the Act, the Claimant must first establish the presence of pneumoconiosis. Pursuant to § 718.202, a living miner can demonstrate pneumoconiosis by means of: (1) chest X-rays interpreted as being positive for the disease;[3] or (2) biopsy evidence; or (3) the presumptions described in §§ 718.304, 718.305 or 718.306 (if applicable); or (4) a finding by a physician that the disease is present, supported by a reasoned medical opinion, if the finding is based on objective medical evidence, such as blood gas studies, pulmonary function studies, physical exams, and medical and work histories. 20 C.F.R. § 718.202.

A. Chest X-rays

Chest X-rays interpreted as being positive for the disease are sufficient to establish the existence of pneumoconiosis. Where two or more X-ray reports are in conflict, the radiologic qualifications of the physicians interpreting the X-rays must be considered. 20 C.F.R. § 718.202(a)(1). An administrative law judge cannot accord greater weight to the interpretation of a physician whose qualifications are unknown. *Stanley v. Director, OWCP*, 7 B.L.R. 1-386 (1984). It is proper to accord more weight to the more recent X-ray films of record. *Clark v. Karst-Robbins Coal Co.*, 12 B.L.R. 1-149 (1989)(*en banc*). Compliance with the quality

[3] Chest X-rays classified as Category 0, including sub-categories of 0/-, 0/0 or 0/1, do not constitute evidence of pneumoconiosis. 20 C.F.R. 718.102(b).

standards is presumed if there is no evidence to the contrary. 20 C.F.R. § 718.102. However, the X-ray must be conducted and reported in accordance with the requirements of § 718.102 and Appendix A of the Regulations in order to constitute evidence of the presence or absence of pneumoconiosis. 20 C.F.R. § 718.102(c).

In the present claim, there are four substantive readings and one quality reading of three chest X-rays. Three of these interpretations were done of the April 19, 2001 film. Dr. Patel found evidence of pneumoconiosis with profusion 1/1, size and shape s/s, in all 6 zones. (DX 11). He also stated that the film revealed a category A large opacity, which was classifiable as complicated pneumoconiosis. He noted that the 2 centimeter mass in the right upper zone was poorly detailed. He also found a coalescence of small opacities in the left upper lung zone. Dr. Patel noted the existence of a few scattered bilateral calcified lung granulomas, which were consistent with healed tuberculosis or histoplasma.

Dr. Wiot reviewed the X-ray and found no evidence of pneumoconiosis. (DX 22; EX 1). He noted opacities, which he classified as profusion 0/1, size and shape r/r, in the three left lung zones. Dr. Wiot concluded that the changes in the right upper lobe were consistent with granulomatous disease with stranding extending from the changes into the right hilum, indicating a past inflammatory process. Drs. Wiot and Patel, both Board-certified Radiologists and B-readers, classified the X-ray as a quality "2" film. Dr. Binns, also a Board-certified Radiologist and B-reader, conducted a quality reading and found the film to be quality grade "2". (DX 12). Dr. Binns further noted a mass in the right upper lung zone.

Dr. Zaldivar, a B-reader, reviewed the X-ray film of January 9, 2001. (DX 23; EX 2). He found that there were no parenchymal or pleural abnormalities consistent with pneumoconiosis. Dr. Zaldivar graded the film as quality "1".

Dr. Cappiello, who is Board-certified in Diagnostic Radiology and a B-reader, evaluated the X-ray of July 24, 2002. (CX 1). He noted that the film was quality "2" due to a left scapular overlay and slight overexposure. Dr. Cappiello observed many small, predominantly rounded, parenchymal opacities throughout both lungs, varying in size from a fraction of a millimeter to three millimeters in diameter. He also found a large opacity in the right upper lobe overlaying the anterior end of the right first rib, approximately 1.3 to 1.4 centimeters in diameter. He further observed coalescent opacities in the left upper lobe and pleural thickening in the right chest wall, measuring seven to eight millimeters at its greatest thickness.

Considering all of the radiographic evidence together, and considering the physicians' qualifications and film quality, I find that the Claimant has established the existence of pneumoconiosis by X-ray evidence.

B. Biopsy Evidence

Pursuant to § 718.202(a)(2), a claimant may establish pneumoconiosis through biopsy evidence. No such evidence was submitted; thus, pneumoconiosis cannot be established in this manner.

C. Presumptions

A claimant may establish pneumoconiosis if the presumptions in §§ 718.304, 718.305, or 718.306 apply. The Claimant is not eligible for the presumption in § 718.305 because this claim was filed after January 1, 1982. Similarly, the Claimant cannot qualify for the § 718.306 presumption because the miner was living after March 1, 1978, and this claim was filed after June 30, 1982.

The Claimant has raised the issue of the applicability of the presumption in § 718.304, arguing that there is credible evidence that he suffers from complicated pneumoconiosis. A claimant may establish a presumption that he is suffering from pneumoconiosis if the presumption in § 718.304 applies. 20 C.F.R. § 718.202(a)(3). Section 718.304 provides for an irrebuttable presumption that a miner is totally disabled due to pneumoconiosis if the miner is suffering from a chronic dust disease of the lung which: 1) Yields at least one large opacity greater than one centimeter in diameter, when diagnosed by chest X-ray; 2) yields massive lesions in the lung when diagnosed by biopsy; or 3) could reasonably be expected to yield such results when diagnosed by other means of acceptable medical procedures. 20 C.F.R. § 718.304.

Drs. Patel and Cappiello diagnosed the Claimant with complicated pneumoconiosis based on X-ray evidence. Dr. Patel observed a poorly detailed mass in the right upper zone, 2 centimeters in diameter, which he stated was likely category A complicated pneumoconiosis. (DX 11). Dr. Cappiello found a large opacity in the right upper lobe, measuring 1.3 to 1.4 centimeters in diameter. He also diagnosed category A complicated pneumoconiosis. (CX 1). Dr. Wiot noted the nodule in the right upper lobe, but concluded that it was consistent with granulomatous disease with stranding extending into the right hilum. (DX 22; EX 1). Dr. Zaldivar observed a mass lesion in the right upper lobe, which he opined was a tumor. He added, however, that it was possible that the lesion is due to pneumoconiosis. (DX 23; EX 2).

There are no biopsy records in this case; thus there is no biopsy evidence of a massive lesion to establish complicated pneumoconiosis.

Dr. Cappiello reviewed a CT scan dated June 4, 1999. (CX 1). He noted a large mass of approximately 3 centimeters in diameter in the right upper lobe. Dr. Cappiello stated that the mass was, in all probability, a large opacity of complicated pneumoconiosis. He compared his CT scan reading to his X-ray review and opined that the lack of significant growth of the mass in the right upper lobe over the three year interval favors a conclusion of complicated pneumoconiosis over neoplasm. Based on his reading of the CT scan, Dr. Cappiello concluded that the Claimant has complicated pneumoconiosis.

Dr. Cappiello further explained his diagnosis during his deposition. He stated that he reviewed both the CT scan and the X-ray, and diagnosed category A complicated pneumoconiosis. (CX 2 at 4-5). He opined that he could better appreciate the size of the opacity and gain a well-balanced perspective by using multiple technologies together. (*Id.* at 8-9). He acknowledged that Dr. Wiot's assertion of a granulomatous process was possible, but less likely because of the appearance of the small opacities that were characteristic of pneumoconiosis, and because he did not see calcified lymph nodes in the mediastinum or right hilum. (*Id.* at 5, 8).

Dr. Cappiello also recognized the possibility of a diagnosis of cancer, but disputed that assertion, noting that the nodule had not grown in size between the 1999 CT scan and the 2002 X-ray. (*Id.* at 5, 8). He further opined that if the mass was a cancerous tumor in 1999, it was unlikely that the Claimant would be alive in 2002. (*Id.* at 8).

I have weighed all of the evidence regarding the Claimant's assertion of complicated pneumoconiosis together. I have considered the X-ray reports, the physicians' credentials, and the films' quality. I have further considered the CT scan report. I note that I give less weight the Dr. Zaldivar because he was equivocal in his conclusion. While he asserted that the mass lesion was a tumor, he admitted that it was possible that it was due to pneumoconiosis. However, he provided no substantive insight into his reasoning for choosing one determination over the other. He recommended the Claimant immediately consult with his physician regarding his finding. To the contrary, I give greater weight to Dr. Cappiello. Dr. Cappiello had the opportunity to view both an X-ray and CT scan. He explained why the combination was important to making an accurate diagnosis. He likewise acknowledged and explained the limitations of the CT scan findings. Finally, Dr. Cappiello thoroughly and clearly discussed the conclusions reached by Drs. Zaldivar and Wiot. Dr. Cappiello's detailed explanations and sound reasoning entitle his findings to greater weight.

After weighing the evidence together, I find that the preponderance of the evidence establishes that the Claimant has complicated pneumoconiosis.

D. Determination by a Physician

A claimant may establish pneumoconiosis based on a physician's opinion, provided that the opinion is based on sound medical judgment and the physician concludes the miner suffers from pneumoconiosis. 20 C.F.R. § 718.202(a)(4). Moreover, pneumoconiosis is a legal term defined by the Act; there is a difference between legal pneumoconiosis and clinical pneumoconiosis. "Clinical pneumoconiosis is only a small subset of the compensable afflictions that fall within the definition of legal pneumoconiosis under the Act." *Richardson v. Director, OWCP*, 94 F.3d 164, 166 n.2 (4th Cir. 1996). Similarly, the "legal definition encompasses a wider range of afflictions than does the more restrictive medical definition of coal workers' pneumoconiosis." *Kline v. Director, OWCP*, 877 F.2d 1175, 1178 (3d Cir. 1989). To qualify under this broader definition of pneumoconiosis, a miner's occupational exposure to coal mine dust must contribute "at least in part" to his pneumoconiosis. *Cornett v. Benham Coal, Inc.*, 227 F.3d 569, 576 (6th Cir. 2000).

The Regulations provide that a disease "arising out of coal mine employment" includes chronic pulmonary disease, or a respiratory/pulmonary impairment substantially aggravated by coal mine dust exposure. 20 C.F.R. § 718.201(b). Thus, the diagnosis of chronic obstructive pulmonary disease is sufficient to establish the existence of pneumoconiosis. Similarly, asthma and asthmatic bronchitis may be sufficient to establish pneumoconiosis if they are related to coal dust exposure. *Tokarcik v. Consolidation Coal Co.*, 6 B.L.R. 1-666 (1983).

Two physicians rendered medical reports in the instant matter. Dr. Rasmussen examined the Claimant and diagnosed coal workers' pneumoconiosis based on the Claimant's work history

and the X-ray taken by Dr. Patel. He also diagnosed chronic bronchitis, from smoking and coal mine dust exposure. (DX 11). Dr. Zaldivar conducted his exam and, after reviewing his findings, including an abnormal chest X-ray with a mass lesion in the right upper lobe, he found no evidence of coal workers' pneumoconiosis. (DX 23; EX 2). The Claimant submitted the deposition of Dr. Cappiello in lieu of a second medical report. Dr. Cappiello testified that he found small opacities of simple pneumoconiosis, in addition to the large opacity, which he concluded was complicated pneumoconiosis.

In light of this apparent dispute between the medical reports, I must weigh the evidence to determine if the Claimant has met his burden of proof. A medical opinion must be documented and well reasoned.[4] A documented opinion is one that sets forth clinical findings, observations, facts and other data upon which the physician based his diagnosis. *Fields v. Island Creek Coal Co.*, 10 B.L.R. 1-19 (1987). An opinion is reasoned if the administrative law judge finds the underlying documentation and data adequately support the physician's conclusions. *Id*

The medical reports of Drs. Rasmussen and Zaldivar are equally well-documented. Both physicians recorded the Claimant's relevant history, conducted an examination, and reviewed results of medical testing. However, as noted above, I accord less weight to Dr. Zaldivar's report because it is not as well-reasoned. Dr. Zaldivar opined that there was no evidence to justify a diagnosis of coal workers' pneumoconiosis, despite noting that the chest X-ray was abnormal. Moreover, he determined the mass lesion on the X-ray to be a tumor, then noted that it could be due to pneumoconiosis. Additionally, I previously found that the X-ray evidence revealed the existence of pneumoconiosis, and the Claimant established the existence of complicated pneumoconiosis. Dr. Zaldivar's opinion is contrary to these findings. Dr. Zaldivar's report is equivocal, if not internally inconsistent, and not supported by the medical evidence of record. Therefore, I accord less weight to his opinion.

Dr. Rasmussen's report is both documented and well-reasoned, and thus, entitled to greater weight. Dr. Rasmussen explained his findings in relation to the Claimant's conditions and background. His conclusions are supported by the medical evidence. Likewise, Dr. Cappiello provided a well-reasoned assessment during his deposition. He thoroughly explained his findings, acknowledged and addressed any shortcomings of his testing procedures, and discussed any contrary medical findings. Thus, I accord greater weight to the medical opinion of Dr. Rasmussen and the deposition testimony of Dr. Cappiello.

Accordingly, I find that the Claimant has established the existence of pneumoconiosis by medical opinion.

After weighing all of the evidence together, including the positive X-ray findings for pneumoconiosis, the evidence of complicated pneumoconiosis, and the physicians' opinions, I find that the Claimant has established the existence of pneumoconiosis.

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[4]An unreasoned or undocumented opinion may be given little or no weight. *Clark v. Karst-Robbins Coal Co.*, 12 B.L.R. 1-149 (1989) (*en banc*).

Material Change in Conditions

Having found the existence of pneumoconiosis, the Claimant has established one of the applicable conditions of entitlement has changed since the effective date of the previous order denying the claim became final. See 20 C.F.R. § 725.309(d). I note that I have now considered the evidence in the Claimant's previous claim for benefits. (DX 1). The record includes an X-ray report by Dr. Daniel, in which he found opacities with profusion 2/1, shape and size q/t, in five zones. Dr. Daniel also noted the presence of category A complicated pneumoconiosis. The February 24, 1993 X-ray was also reviewed by Dr. Sargent, who found no parenchymal or pleural abnormalities consistent with pneumoconiosis. He noted, however, scattered, ill-defined nodules of an unknown ideology. The previous record also included a medical report by Dr. Daniel, who diagnosed the Claimant with coal workers' pneumoconiosis, based on the X-ray evidence and the history of coal mine dust exposure, and chronic obstructive pulmonary disease, based on the Claimant's smoking history and abnormal vent studies.

None of this evidence alters my findings with regard to the existence of pneumoconiosis. This evidence provides additional support for a finding of pneumoconiosis. However, this evidence would be entitled to less weight when considered against the more recent evidence, submitted as part of the Claimant's current claim for benefits.

II. Cause of Pneumoconiosis

Once it is determined that a miner suffers from pneumoconiosis, it must be determined whether the miner's pneumoconiosis arose, at least in part, out of coal mine employment. 20 C.F.R. § 718.203(a). If a miner, who is suffering from pneumoconiosis, was employed in the coal mines for at least ten years, there shall be a rebuttable presumption that the pneumoconiosis arose out of such employment. 20 C.F.R. § 718.203(b).

The Claimant has established nearly 40 years of coal mine employment; thus, he is entitled to the presumption that his pneumoconiosis was caused by his coal mine employment. The Employer has not rebutted the presumption. Therefore, the Claimant has established that his pneumoconiosis arose, at least in part, out of coal mine dust exposure.

III. Evidence of Total Disability

Total disability is defined as pneumoconiosis which prevents a miner from performing his usual coal mine work or other gainful employment. 20 C.F.R. §§ 718.204(b)(1-2), 718.305(c). Pursuant to § 718.204(c), in the absence of contrary probative evidence, evidence that meets the quality standards set forth in subsection (c) shall establish the miner's total disability. The administrative law judge must consider all the evidence of record and determine whether the record contains contrary evidence. If so, the judge must assign this evidence the appropriate weight and determine "whether it outweighs the evidence supportive of a finding of total disability." *Fields v. Island Creek Coal Co.*, 10 B.L.R. 1-19, 1-21 (1987). There are four methods to establish total disability, unless the miner can establish that he is entitled to the irrebuttable presumption in § 718.304: (1) pulmonary function studies; (2) arterial blood gas

studies; (3) evidence of cor pulmonale with right-sided congestive heart failure; and (4) reasoned medical opinions. 20 C.F.R. § 718.204(b)(2).

I note that the Employer has contested the issue of the Claimant's total disability. (TR 5-6). At the hearing, the Claimant, however, noted through counsel that he is not alleging a totally disabling respiratory ailment. The only issue alleged by the Claimant is the existence of complicated pneumoconiosis, which, if found, would entitle the Claimant to an irrebuttable presumption that he is totally disabled. *See* 20 C.F.R. § 718.304.

I have found previously that the Claimant is entitled to the irrebuttable presumption that he is totally disabled under 20 C.F.R. § 718.304. Based on the medical evidence, including the X-rays and CT scan, the Claimant has established the existence of complicated pneumoconiosis. Accordingly, the Claimant has established that he is totally disabled. Despite this finding, I will consider the alternative means for determining total disability.

A. Pulmonary Function Studies

There are two pulmonary function studies in the record for the present claim, and one from the previous claim. The tests given by Dr. Rasmussen on April 19, 2001, (DX 11) and Dr. Zaldivar on January 9, 2002, (DX 23; EX 2) did not yield qualifying results. Dr. Zaldivar noted the presence of a mild irreversible obstruction, normal lung volumes, and a mild diffusion impairment. The test of February 24, 1993 also did not produce qualifying results, but the physician noted the presence of a mild obstructive defect. (DX 1).

The Claimant has not demonstrated total disability by pulmonary function study evidence.

B. Arterial Blood Gas Studies

There are two arterial blood gas tests in the record for the present claim, and one from the previous claim in the record. Neither the pre- nor post-exercise test conducted by Dr. Rasmussen on April 19, 2001, yielded a qualifying result. (DX 11). Similarly, neither the pre- nor post-exercise test conducted by Dr. Zaldivar on January 9, 2002, yielded qualifying results. (DX 23; EX 2). Dr. Zaldivar observed a mild to moderate limitation to exercise due to pulmonary causes. He also noted that the rise in pCO_2 raises the possibility of a bronchospasm. The pre-exercise tests and the multiple post-exercise tests conducted on February 24, 1993, did not yield qualifying results.

The Claimant has not established total disability by arterial blood gas test evidence.

C. Cor Pulmonale

There is no evidence in the record of cor pulmonale. Thus, the Claimant cannot establish total disability by this condition.

D. Medical Opinions

Drs. Rasmussen, Zaldivar and Daniel concur that the Claimant is not totally disabled. Dr. Rasmussen stated that the Claimant has minimal loss of lung function, but retains the pulmonary capacity to perform his last regular coal mine job. (DX 11). Dr. Zaldivar observed a mild pulmonary impairment, but that from a pulmonary standpoint, the Claimant was not disabled and was capable of performing his usual coal mine work or work requiring similar exertion. (DX 23; EX 2). Dr. Daniel found no evidence of a significant pulmonary dysfunction present in 1993. (DX 1).

Accordingly the Claimant has failed to establish total disability by medical opinion evidence.

The Claimant has not established total disability by any of the alternative means provided for in the Regulations. However, the Claimant has established that he has complicated pneumoconiosis, and thus, is entitled to the irrebuttable presumption that he is totally disabled, as set forth in 20 C.F.R. § 718.304. Therefore, the Claimant has established that he is totally disabled.

IV. Cause of the Disability

In order to receive benefits under the Act, the Claimant must demonstrate that he is totally disabled due to pneumoconiosis. The Regulations require a finding that pneumoconiosis is a substantially contributing cause of the respiratory or pulmonary impairment. 20 C.F.R. § 718.204(c)(1). A "substantially contributing cause" means pneumoconiosis has a material adverse effect on the miner's condition, or materially worsens an impairment that is caused by a disease or exposure unrelated to coal mine employment.

Twenty C.F.R. § 718.304 provides that the irrebuttable presumption establishes that the miner's total disability is due to pneumoconiosis if the applicable conditions are met. As discussed above, I have previously found that the Claimant established the existence of complicated pneumoconiosis under § 718.304, and was thus entitled to the irrebuttable presumption that he is totally disabled. Therefore, he is also entitled to the presumption that his disability is due to pneumoconiosis.

CONCLUSION

The Claimant has established the existence of pneumoconiosis, as well as the existence of complicated pneumoconiosis. He is entitled to the presumption that the disease arose, at least in part, out of his coal mine dust exposure and that presumption has not been rebutted. Having established the existence of complicated pneumoconiosis, the Claimant has likewise established that he is entitled to the irrebuttable presumption that he is totally disabled, and that his disability is due to pneumoconiosis.

ATTORNEY'S FEES

The award of an attorney's fee under the Act is permitted only in cases in which the Claimant is found to be entitled to benefits. Since benefits are awarded in this case, the Act entitles Claimant's counsel to an award of fees and costs. No award is made herein since no application has been received. Thirty days are hereby allowed to Claimant's counsel for the submission of such an application. Counsel's attention is directed to 20 C.F.R. §§ 725.365 and 725.366. A service sheet showing that service has been made upon all parties, including the Claimant, must accompany the application. Parties have ten days following the receipt of such application within which to file any objections. The Act prohibits the charging of a fee in the absence of an approved application.

ORDER

The claim for benefits filed by Angelo Prunesti, under the Black Lung Benefits Act, is hereby GRANTED.

It is hereby ORDERED that Anker West Virginia Mining Company, Inc., and its Carrier, shall pay to the Claimant, Angelo Prunesti, all benefits to which he is entitled under the Act, commencing from the filing date of the subsequent claim, January 23, 2001.

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ROBERT J. LESNICK
Administrative Law Judge

RJL/SR/dmr

NOTICE OF APPEAL RIGHTS: Pursuant to 20 C.F.R. § 725.481, any party dissatisfied with this Decision and Order may appeal it to the Benefits Review Board within thirty (30) days from the date of this Decision and Order, by filing a notice of appeal with the **Benefits Review Board, P.O. Box 37601, Washington, D.C., 20012-7601**. A copy of a notice of appeal must also be served on Donald S. Shire, Esquire, Associate Solicitor for Black Lung Benefits, Room N-2117, Frances Perkins Building, 200 Constitution Avenue, N.W., Washington, D.C., 20210.